

1 EDMUND G. BROWN JR.
Attorney General of California
2 GREGORY J. SALUTE
Supervising Deputy Attorney General
3 ALVARO MEJIA
Deputy Attorney General
4 State Bar No. 216956
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 897-0083
6 Facsimile: (213) 897-2804
Attorneys for Complainant
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8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 2010-220

12 **MARILYN ROSE STRONG**
aka MARILYN R. FASANELLA
13 **aka MARILYN R. RUSSELL**
1640 Holguin Street
14 Lancaster, CA 93534

ACCUSATION

15 Registered Nurse License No. 305969

16 Respondent.
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19 Complainant alleges:

20 **PARTIES**

21 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
22 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department
23 of Consumer Affairs.

24 2. On or about September 30, 1979, the Board of Registered Nursing (Board) issued
25 Registered Nurse License No. 305969 to Marilyn Rose Strong, aka Marilyn R. Fasanella, and aka
26 Marilyn R. Russell (Respondent). The Registered Nurse License was in full force and effect at all
27 times relevant to the charges brought herein and will expire on October 31, 2011, unless renewed.

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8. Section 2762 states, in pertinent part:

“In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

“(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

“(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

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“(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.”

REGULATORY PROVISIONS

9. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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10. California Code of Regulations, title 16, section 1443 states, in pertinent part:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse"

11. California Code of Regulations, title 22, section 72313, subdivision (a)(6), states that "[m]edications shall be administered as soon as possible, but no more than two hours after doses are prepared, and shall be administered by the same person who prepares the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber."

COST RECOVERY

12. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES / DANGEROUS DRUGS

13. Benadryl is the trade name for the drug diphenhydramine, which is classified as an antihistamine, sedative, Anti-Parkinson, Anaphylaxis. In 50 mg capsules or tablets this is a prescription drug and considered a dangerous drug pursuant to section 4022.

14. Demerol, a brand of meperidine hydrochloride, a derivative of the narcotic substance pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(17) and is categorized as a dangerous drug pursuant to section 4022.

15. Dilaudid is a trade name for hydromorphone, an opium derivative, which is classified as a Schedule II Controlled Substance pursuant to Health and Safety Code section 11055(b)(1)(k) and is categorized as a dangerous drug pursuant to 4022.

16. Morphine/Morphine Sulfate, a narcotic substance, is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(M) and is categorized as a dangerous drug pursuant to section 4022.

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1 17. Reglan is a brand name for metoclopramide and a dangerous drug pursuant to section
2 4022(c).

3 18. Vicodin ES, a trade name for the combination drug containing hydrocodone bitartrate
4 (opioid analgesic) and acetaminophen, is a Schedule III controlled substance as defined in Health
5 and Safety Code section 11056(e)(7) and is categorized as a dangerous drug according to section
6 4022.

7 **FIRST CAUSE FOR DISCIPLINE**

8 **(Self Administration of a Controlled Substance)**

9 19. Respondent is subject to disciplinary action under section 2761, subdivision (a), on
10 the grounds of unprofessional conduct in that on or about May 24, 2006, Respondent, while
11 employed as a registered nurse at Antelope Valley Hospital, Lancaster, California, admitted to
12 self-medicating herself with the controlled substance and dangerous drug, Dilaudid, without a
13 valid prescription.

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Dangerous Use of a Controlled Substance)**

16 20. Respondent is subject to disciplinary action under sections 2761, subdivisions (a) and
17 (d), and 2762, subdivision (b), on the grounds of unprofessional conduct, in that on or about May
18 24, 2006, Respondent presented herself for work as a registered nurse to Antelope Valley
19 Hospital, Lancaster, California, while under the influence of a controlled substance and dangerous
20 drug. Respondent tested positive for Dilaudid, without a valid prescription.

21 **THIRD CAUSE FOR DISCIPLINE**

22 **(Illegally Obtain / Possess a Controlled Substance)**

23 21. Respondent is subject to disciplinary action under sections 2761, subdivisions (a) and
24 (d), and 2762, subdivision (a), on the grounds of unprofessional conduct, in that on or about May
25 24, 2006, Respondent admitted to obtaining and possessing Dilaudid, a controlled substance and
26 dangerous drug, from her daughter's boyfriend's prescription bottle. Complainant refers to and
27 by this reference incorporates the allegations set forth above in paragraphs 19 and 20, inclusive,
28 as though set forth fully.

1 **FOURTH CAUSE FOR DISCIPLINE**

2 **(False Records)**

3 22. Respondent is subject to disciplinary action under section 2761, subdivisions (a) and
4 (d), and 2762, subdivision (e), on the grounds of unprofessional conduct, in that while employed
5 as a registered nurse at Antelope Valley Hospital, Lancaster, California, Respondent falsified,
6 made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patients
7 records pertaining to controlled substances and dangerous drugs, as follows:

8 a. **Patient MR 120204938.**

9 (1) On or about May 3, 2006, the patient's Medication Administration Record (MAR)
10 records physician's orders were 4 mg Dilaudid IV every three (3) hours as needed.

11 (2) On or about May 3, 2006, at 9:33 am, Respondent cancelled removal¹ of 2 mg
12 Dilaudid for this patient. Respondent recorded on the patient's Medication Administration
13 Record (MAR) administration of 4 mg of Dilaudid to this patient. Respondent's documentation is
14 incorrect, inconsistent, and unintelligible.

15 (3) On or about May 3, 2006, at 6:29 pm, Respondent removed 2 mg Dilaudid for this
16 patient without cancellation or wastage. Respondent recorded on the patient's MAR
17 administration of this medication was withheld from the patient. Respondent failed to account for
18 2 mg Dilaudid in any hospital records.

19 (4) On or about May 3, 2006, the MAR records physician's orders were 50 mg Benadryl
20 IV every three hours as needed.

21 (5) On or about May 3, 2006, at 6:28 pm, Respondent removed 50 mg Benadryl for this
22 patient without cancellation or wastage. Respondent recorded on the patient's MAR
23 administration of this medication was withheld from the patient. Respondent failed to account for
24 50 mg Benadryl in any hospital records.

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26 1. ¹ "Removals" of medication are made from the hospital's Pyxis. Pyxis is a trade
27 name for the automated single-unit dose medication dispensing system that records information
28 such as patient name, physician orders, date and time medication was withdrawn, and the name of
the licensed individual who withdrew and administered the medication.

1 b. **Patient MR 120281282.** On or about May 4, 2006, physician's orders were 1-2 mg
2 Dilaudid IV every 2-3 hours as needed. At 7:54 am, Respondent removed 2 mg Dilaudid for this
3 patient. Respondent recorded on the MAR that at 7:50 am, 2 mg Dilaudid was wasted.
4 Respondent recorded on the nursing notes that 2 mg Dilaudid was wasted at bedside. Respondent
5 failed to have a witness verify her wastage of 2 mg Dilaudid. Respondent failed to account for 2
6 mg Dilaudid in any hospital records.

7 c. **Patient MR 120242953.**

8 (1) On or about May 8, 2006 and May 10, 2006, the physician's orders were 100 mg
9 Meperidine (Demerol) every 2 hours as needed.

10 (2) On or about May 8, 2006, at 5:18 pm, Respondent removed 2 - 50 mg Demerol for
11 this patient without cancellation or wastage. Respondent failed to record on the patient's MAR
12 administration of the medication. Respondent failed to account for 100 mg Demerol in any
13 hospital records.

14 (3) On or about May 8, 2006, at 7:18 pm, Respondent removed 2 - 50 mg Demerol for
15 this patient, and at 7:19 pm, Respondent cancelled removal of 2 - 50 mg Demerol for this patient.
16 Without removal of 100 mg Demerol, Respondent recorded on the MAR administration of 100
17 mg Demerol to this patient. Respondent's documentation is incorrect, inconsistent, and
18 unintelligible.

19 (4) On or about May 10, 2006, at 5:26 pm, Respondent removed 2 - 50 mg Demerol for
20 this patient without cancellation or wastage. Respondent failed to record on the patient's MAR
21 administration of the medication. Respondent failed to account for 100 mg Demerol in any
22 hospital records.

23 (5) On or about May 10, 2006, at 7:19 pm, Respondent removed 2 - 50 mg Demerol for
24 this patient without cancellation or wastage. Respondent failed to record on the patient's MAR
25 administration of the medication. Respondent failed to account for 100 mg Demerol in any
26 hospital records.

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1 d. **Patient MR 120354287.** On or about May 23, 2006, physician's orders were 1 mg
2 Hydromorphone IV every 2 hours as needed for severe pain. At 9:31 am, Respondent removed 2
3 mg Dilaudid for this patient without cancellation or wastage. Respondent failed to record on the
4 patient's MAR administration of the medication. Respondent failed to account for 2 mg Dilaudid
5 in any hospital records.

6 e. **Patient MR 12063163.**

7 (1) On or about May 23, 2006, physician's orders were 1 Vicodin ES four (4) times a day
8 as needed. At 2:30 pm, Respondent removed 1 Vicodin ES for this patient without cancellation
9 or wastage. Respondent failed to record on the patient's MAR administration of the medication.
10 Respondent failed to account for 1 Vicodin ES in any hospital records.

11 (2) On or about May 23, 2006, this patient had no physician's orders for Morphine. At
12 6:50 pm, Respondent removed 4 mg Morphine for this patient without cancellation or wastage.
13 Respondent removed the wrong medication for this patient. Respondent failed to record
14 administration of the medication on any hospital records. Respondent failed to account for 4 mg
15 Morphine in any hospital records.

16 f. **Patient MR 120365671.**

17 (1) On or about May 23, 2006, physician's orders were 4 mg Morphine IV every 4 hours
18 as needed. At 12:06 pm, Respondent removed 4 mg Morphine for this patient without
19 cancellation or wastage. Respondent failed to record administration of the medication on any
20 hospital records. Respondent failed to account for 4 mg Morphine in any hospital records.

21 (2) On or about May 23, 2006, physician's orders were Reglan IV every 6 hours as need
22 for nausea. At 12:07 pm, Respondent removed 5 mg Reglan for this patient without cancellation
23 or wastage. Respondent failed to record administration of the medication on any hospital records.
24 Respondent failed to account for 5 mg Reglan in any hospital records.

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1 **FIFTH CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct)**

3 23. Respondent is subject to disciplinary action under section 2761, subdivision (a), in
4 that on or between May 3, 2006 and May 24, 2006, Respondent committed acts of unprofessional
5 conduct when:

6 a. Respondent admitted that some of her nursing notes were confusing and refused to
7 review the charts for inconsistencies when requested;

8 b. Respondent failed to document administration of medications as ordered;

9 c. Respondent failed to administer medications to patients;

10 d. Respondent failed to account for 50 mg Benadryl, 300 mg Demerol, 6 mg Diaudid, 8
11 mg Morphine, and 5 mg Reglan in any hospital record;

12 d. Respondent failed to follow physician orders for medication administration; or

13 e. Respondent knowingly reported to work in an impaired state.

14 Complainant refers to and by this reference incorporates the allegations set forth above in
15 paragraphs 19 - 22, inclusive, as though set forth fully.

16 **SIXTH CAUSE FOR DISCIPLINE**

17 **(Gross Negligence)**

18 24. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1),
19 and California Code of Regulations, title 16, section 1442, on the grounds of unprofessional
20 conduct, in that on or between May 3, 2006 and May 24, 2006, Respondent committed acts of
21 gross negligence when she repeatedly deviated from the accepted standards of practice,
22 repeatedly failed to provide nursing care as required, and repeatedly failed to exercise ordinary
23 precaution or apply basic safety precautions in which she knew or should have known that the
24 patient's life could be jeopardized. Complainant refers to and by this reference incorporates the
25 allegations set forth above in paragraphs 19 - 23, inclusive, as though set forth fully.

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SEVENTH CAUSE FOR DISCIPLINE

(Incompetence)

25. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), and California Code of Regulations, title 16, section 1443, on the grounds of unprofessional conduct, in that on or between May 3, 2006 and May 24, 2006, Respondent committed acts of incompetence when she failed to exercise that degree of learning, skill, and experience ordinarily possessed and exercised by a competent registered nurse. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 19 - 23, inclusive, as though set forth fully.


PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License No. 305969, issued to Respondent;
2. Ordering Respondent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3; and
3. Taking such other and further action as deemed necessary and proper.

DATED: _____

10/21/09


LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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